

Statement for the Record

Submitted by:  
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Before the Senate Finance Committee  
May 3, 2023 Hearing  
“Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of  
Ghost Networks”



May 17, 2023

**Re: Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks**

Chair Wyden, Ranking Member Crapo, and Members of the Senate Finance Committee,

The Legal Action Center, Center for Medicare Advocacy, and Medicare Rights Center commend the Senate Finance Committee for its leadership on improving access to mental health care and for convening the May 3<sup>rd</sup> hearing on “Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks.”

The Legal Action Center (LAC) is a non-profit organization that uses legal and policy strategies to fight discrimination, build health equity, and restore opportunity for people with arrest and conviction records, substance use disorders, and HIV or AIDS. LAC works to expand access to substance use disorder and mental health care through enforcement of the Mental Health Parity and Addiction Equity Act (Parity Act) in public and private insurance, including our Medicare Addiction Parity Project, which seeks to improve access to substance use disorder treatment in Medicare in a comprehensive and equitable manner.<sup>1</sup> The Center for Medicare Advocacy (the Center) is a national, non-profit, law organization that works to advance access to comprehensive Medicare coverage, health equity, and quality health care for older people and people with disabilities. Founded in 1986, the Center focuses on the needs of people with longer-term and chronic conditions. The organization’s work includes legal assistance, advocacy, education, analysis, policy initiatives, and litigation of importance to Medicare beneficiaries nationwide. Our systemic advocacy is based on the experiences of the real people who contact the Center every day. Headquartered in Connecticut and Washington, DC, the Center also has attorneys in CA and MA. The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Our organizations appreciate the opportunity to provide a statement for the record.

A. Ghost Networks & Provider Directories

Our organizations strongly agree with the Chairman’s remarks, that “when insurance companies host ghost networks, they are selling health coverage under false pretenses.” We further agree that eliminating ghost networks will require more audits, greater transparency, and stronger consequences for insurance companies that are providing false or incorrect information to their enrollees. We urge Congress to **pass Senator Wyden and Senator Bennet’s “Mental Health Care for Americans Act,”** which would

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<sup>1</sup> “Medicare Addiction Parity Project,” Legal Action Center, <https://www.lac.org/major-project/mapp>.

**require accuracy and transparency in Medicare Advantage provider directories and audits by the Secretary**, in addition to other critical provisions to require Parity in Medicare Advantage and Part D plans as well as fee-for-service Medicaid.

As noted in the testimony by Mental Health America, provider directory requirements alone are not enough. We recommend the Committee establish strong compliance and enforcement provisions for maintaining accurate provider directories. Respectfully, we believe incentives should not be needed for Medicare Advantage plans for this purpose. Our government is paying these private health plans billions of dollars to provide medically necessary care to older adults and people with chronic disabilities, they are failing to do so, and they should not be given incentives to do the job they are contracted to do. As noted by each of the witnesses, inaccurate provider directories prevent consumers from making informed decisions about which health plan to select, lead to a delay in care – that may result in abandoning care altogether – that is disproportionately harmful to people with mental health conditions and substance use disorders, and result in unnecessary additional costs to consumers who are forced to go out-of-network because the networks are inadequate to meet their needs. Our organizations urge Congress and the Centers for Medicare and Medicaid Services (CMS) to **hold Medicare Advantage plans accountable through sufficient penalties when they both fail to provide medically necessary services to their enrollees and when they misrepresent or falsify information to individuals and the federal government by putting forth inaccurate network directories.**<sup>2</sup>

The Senate Finance Committee majority staff and witnesses highlighted findings from secret shopper surveys, demonstrating their usefulness in assessing the accuracy of provider directories and determining whether patients are truly able to get appointments in a timely manner. As noted by Senator Menendez, CMS recently proposed a rule that would require an independent entity to conduct annual secret shopper surveys of Medicaid managed care organizations for provider directory accuracy for outpatient mental health and substance use disorder providers, as well as several other provider types.<sup>3</sup> We applaud CMS for this proposal and urge Congress **to establish consistency across health plans and financing systems and require comparable independent secret shopper survey requirements in Medicare Advantage and commercial insurance plans.**

We appreciate Ranking Member Crapo’s and many of the Senators’ comments on the importance of telehealth in expanding access to mental health and substance use disorder care. We concur that telehealth offers a critical opportunity to bring culturally and linguistically effective treatment to more people, especially during the ongoing workforce crisis. We strongly urge Congress to **make permanent the telehealth flexibilities that were established during the COVID-19 pandemic**, especially where telehealth can be used to fill in gaps in mental health professional shortage areas and counties in which consumers have limited or no access to prescribers of medications for opioid use disorder and other substance use disorder providers. However, we believe telehealth should supplement in person care, not replace it. Many individuals still prefer in-person care, a hybrid model of care, or telehealth only when it is delivered by an in-state provider who is familiar with all the local resources and referrals. With this in mind, CMS has articulated in its proposed rule for Medicaid that it is “appropriate to prohibit managed care plans from meeting appointment wait time standards with telehealth appointments alone,” as doing so would mask whether the appointments being offered by providers are “consistent with expectations

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<sup>2</sup> See 42 U.S.C. 1395w-27(g)(1)(A) and (E).

<sup>3</sup> “Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality,” Centers for Medicare & Medicaid Services (CMS), 88 Fed. Reg. 28092, 28101-02 (proposed May 3, 2023).

and enrollees' needs."<sup>4</sup> Thus, as Congress considers provider directory and network adequacy standards, we recommend **requiring all Medicare Advantage provider directories to identify the delivery modality providers use and limit the counting of telehealth visits to meet appointment wait time standards or, at a minimum, report telehealth utilization separately, consistent with Qualified Health Plans and with CMS's proposal for Medicaid managed care organizations.**<sup>5</sup>

## B. Network Adequacy

Our organizations also concur with the American Medical Association's testimony and Senator Warren's statements that provider directory inaccuracies often mask another significant problem: inadequate networks that are unable to serve the needs of the plan's enrollees. Medicare Advantage plans must be required to meet network adequacy standards for outpatient mental health and substance use disorder care – both geographic time and distance standards as well as appointment wait time standards – and they must be held accountable for failing to do so. While CMS has developed strong geographic time and distance network adequacy standards for mental health care, it has failed to do so for substance use disorder care.<sup>6</sup> Yet, over 50,000 Medicare Part D beneficiaries experienced an overdose in 2021 at a time when fewer than 1 in 5 of the over 1 million Medicare beneficiaries with an opioid use disorder received medications for opioid use disorder.<sup>7</sup> Furthermore, CMS's recent final rule for Medicare Advantage set an appointment wait time standard for routine visits at 30 business days for mental health and substance use disorder care, even though the final standard in Marketplace plans and the proposed standard in Medicaid managed care plans is 10 business days. Once more, we urge Congress to establish consistent standards across payment systems and **require Medicare Advantage plans to comply with these more appropriate wait time standards to ensure networks are adequate for beneficiaries to access mental health and substance use disorder care.**

As part of improving network adequacy, Congress must consider the payment rates of Medicare Advantage plans and how offering low payment rates or failing to negotiate contributes to the insufficient networks and lack of access to mental health and substance use disorder services. CMS's recently proposed Medicaid/CHIP rule would continue to allow Medicaid managed care organizations to get exceptions from the State for failing to meet timely appointment wait time standards, but it would also add a requirement that States consider the payment rates offered by the managed care organization when granting exceptions, recognizing that these "plans sometimes have difficulty building networks that meet network adequacy standards due to low payment rates."<sup>8</sup> The agency also proposed requiring managed care plans to conduct and submit to the State a payment analysis including paid claims data to assess and compare rates for critical services, including mental health and substance use disorder services, because "a critical component of building a managed care plan network is payment, low payment rates can harm access to care," and "provider payment rates in managed care are inextricably linked with provider

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<sup>4</sup> *Id.* at 28102-03.

<sup>5</sup> *Id.*

<sup>6</sup> "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program," Centers for Medicare & Medicaid Services (CMS), 88 Fed. Reg. 22120, 22168-71 (Apr. 12, 2023).

<sup>7</sup> U.S. Dep't. Health & Human Services, Office of the Inspector General, "Opioid Overdoses and the Limited Treatment of Opioid Use Disorder Continue to be Concerns for Medicare Beneficiaries" (Sept. 2022), <https://oig.hhs.gov/oei/reports/OEI-02-22-00390.pdf>.

<sup>8</sup> "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality," Centers for Medicare & Medicaid Services (CMS), 88 Fed. Reg. 28092, 28100 (proposed May 3, 2023).

network sufficiency and capacity.”<sup>9</sup> Our organizations recommend Congress **improve data collection, transparency, and oversight of the payment rates and credentialing processes of Medicare Advantage organizations and ensure that these plans are not using policies and practices that intentionally or in practice limit networks or access to medically necessary care for enrollees.**

### C. Mental Health Parity and Addiction Equity

The significant access gaps for mental health and substance use disorder care highlighted at this hearing would also be ameliorated by another provision of the Mental Health Care for Americans Act: applying the Parity Act to Medicare Advantage and Part D plans and to Medicaid fee-for-service plans. Among Americans ages 65 and over in 2021, approximately 6.5 million individuals had a mental health condition and over 4.3 million individuals had a substance use disorder.<sup>10</sup> It is unacceptable that millions of Americans lack the anti-discrimination protections in their insurance that are afforded to those in other commercial insurance plans and Medicaid managed care plans. Lack of parity protections translate to inequitable networks of mental health and substance use disorder providers, insufficient coverage of the full scope of needed services, and greater barriers to services including prior authorizations and other utilization management practices. **Our organizations strongly urge Congress to use every available strategy to address America’s mental health crisis and the opioid public health emergency by applying the Parity Act to all parts of Medicare and to fee-for-service Medicaid.**

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Thank you for your work to reduce barriers to mental health and substance use disorder care. If you have any questions about our statement, please contact Deborah Steinberg at [dsteinberg@lac.org](mailto:dsteinberg@lac.org).

Sincerely,



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<sup>9</sup> *Id.* at 28104-05.

<sup>10</sup> Substance Abuse and Mental Health Services Administration (SAMHSA), “2021 National Survey on Drug Use and Health (NSDUH) Detailed Tables,” Table 5.4A and 6.1A (Jan. 4, 2023) <https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables>.